APPLICATION FOR PARATRANSIT ELIGIBILITY
PLEASE READ BEFORE COMPLETING THE APPLICATION

Dear Applicant:

The questions in PART A of this application represent the first step in the process to certify your application for eligibility to use CCT's Paratransit Service. Please answer each question because the answer will assist us in determining the appropriate service to match your abilities. **HAVING A DISABILITY DOES NOT AUTOMATICALLY MAKE SOMEONE ELIGIBLE FOR PARATRANSIT SERVICE.** Eligibility is determined based on how the disability restricts the applicant to travel to and ride the regular (big), fixed route bus. **ALL QUESTIONS ON THIS APPLICATION ARE REFERRING TO THE REGULAR (BIG) FIXED ROUTE BUS.**

It is your responsibility to return the completed, signed PART A portion of the certification process to CCT. You must sign the Authorization Page of this form, authorizing your Licensed/certified Health Care Professional to release information about your disability. **On the Authorization Page, please be certain to provide complete information of the Licensed/certified Health Care Professional who can appropriately answer questions about your disability and your ability to travel.**

CCT will forward PART B of the application to the Licensed/certified Health Care Professional who is listed on Part A on the day it is received in our office. Your application will be considered complete once your Licensed/certified Health Care Professional has completed and returned PART B to CCT. CCT will provide a decision as to your eligibility within 21 days once the completed application is received.

Please note: The person filling out Part A of this application cannot be the same person who will fill out Part B from the Licensed/certified Health Care Professional.

ALL FIXED ROUTE BUSES ARE WHEELCHAIR ACCESSIBLE

PART A APPLICANT INFORMATION (PLEASE PRINT) DATE:_____

Please check one: Initial Application_____ Re-certification Application_____

Last Name_____First Name_____ MI____

Street Address_____

City_____State____Zip Code_____

Email address for any written correspondence (for visually impaired) _____

_____

Closest bus stop to your residence. (If you are not sure, please call (770) 427-4444.) ____

_____

Name of subdivision or apartment complex: _____

Nearest major intersecting street _____

_____

Nearest cross street to your residence _____

Home phone number (___)_____Cell phone number (___) _____

In case of emergency contact: Name _____

Alternative emergency number (Other than your home phone)_( ) _____

Date of Birth_____ Male_____ Female _____

What is the medical name of your disability? _____

Is this disability temporary?_____If yes, how long do you anticipate your disability will affect you? _____

How does this condition affect your ability to ride the regular (big), fixed route bus service? Be very specific. _____

_____

_____

Are there any other physical or mental disabilities that impact your **FUNCTIONAL ABILITY** to ride the regular (big), fixed route bus service? Yes _____No _____

If yes, please describe: _____

_____

Do any of the following conditions affect your travel? Please explain.

Hills _____

No curb cut _____

No sidewalk _____

Weather/temperature sensitivity _____

Can you wait 30 minutes at a CCT bus stop that **DOES NOT** have seats and a shelter?
Yes _____ No _____ If no, please explain why. _____
_____

Can you wait 30 minutes at a CCT bus stop that **DOES** have seats and a shelter?
Yes _____ No _____ If no, please explain why. _____
Can you wait 30 minutes at a CCT bus stop unassisted? Yes _____ No _____
If no, please explain why. _____

How far can you walk without the assistance of another person?
The length of one football field? 300ft Yes _____ No _____
One lap around a 1/4 mile track? Yes _____ No _____
Two laps around a 1/4 mile track? Yes _____ No _____
Three laps around a 1/4 mile track? Yes _____ No _____

Do you use a mobility device to travel? Yes _____ No _____
Please check all that apply.
White Cane _____ Orthopedic Cane (three or four prong base) _____ Standard Cane _____ Walker _____ Braces _____ Crutches _____
Manual Wheelchair _____ Motorized Wheelchair _____ Scooter _____
What is the height/width of your wheelchair/scooter? Height _____ Width _____
What is the weight of your wheelchair/scooter while it is occupied by you? _____

Do you require the use of a service animal? Yes __ No __
If yes, what type of animal is used? _____
What function does the animal provide? _____

Do you travel with portable medical equipment? Yes _____ No _____
If yes, what type of portable medical equipment? _____

Do you require a personal care assistant (PCA) to travel with you to provide transportation assistance? Yes _____ No _____ If yes, please tell us about the specific assistance you require. _____
_____
_____

If you do not require a personal care assistant for bus travel, are you required to be met by a caregiver when existing the bus? Yes _____ No _____ If the bus arrives at your destination and the caregiver is not there to take you off the bus, who must be contacted? Name _____ Telephone number (___) _____
Please note: If contact number does not answer or is disconnected, DFCS/911 will be called to take the passenger off the bus.

Are there situations when you will not require this type of assistance? Please explain. ___
_____
_____

Do you need assistance recognizing your stop? Yes _____ No _____ If yes, please explain _____

Do you use a communication device to communicate with others such as a driver?
Yes __ No __Letter Board? _____Route ID Card? _____ Picture board? _____

Do you require an alternate format for the Rider's Guide, Fixed Route schedules or any written correspondence? Yes _____ No _____ Please check the format you would like to receive them in? **Check only one format:** CD _____ Audio tapes _____
Braille _____Email _____Large print_____
Do you have email in order to receive correspondence from CCT? Yes __ No __
If yes, please print email address. _____

Are you able to walk up 12-14 inch steps unassisted? Yes _____ No _____
If unassisted, can you grip a handrail to support yourself? Yes ___ No _____
Do you require walking on a lift and gripping the handrail in order to board/exit the bus?
Yes _____ No _____

How do you travel now? Please check all that apply.
Wheelchair/scooter _____Pushed by caregiver or self? _____Walk _____
Drive myself _____Passenger in someone else's car _____
Regular (big), fixed route bus service _____Other van service _____

When was the last time you rode a regular (big), fixed route bus? _____
Why did you stop using the regular (big), fixed route bus? _____
Would you be able to ride the regular (big), fixed route bus system if you receive mobility training? _____
Have you ever been trained in the use of CCT's bus system? _____
Who trained you in the use of the bus system? _____
Have you ever been trained in the use of any other bus system? _____

Do you feel that you could ride the regular (big), fixed route bus if the paratransit van could get you to a regular (big), fixed route bus stop? Yes . No _____
If the answer is no, please explain how your disability restricts this. _____
_____
_____

Do you feel that you could ride the regular (big), fixed route bus if your trip involved riding the regular (big), fixed route bus, getting off at a bus stop and the paratransit van could pick you up at the bus stop and take you to the remainder of your trip?
Yes _____ No _____If no, please explain why. _____
_____
_____

To the best of my knowledge, the information I have provided as part of this application has been properly recorded. I have reviewed all answers and certify that the information is complete and correct. I understand that any intentional false or misleading information may be grounds for denial of service.

_____

Signature of applicant, representative, or guardian:

Date:_____

PATIENT CONSENT TO RELEASE & DISCLOSURE OF MEDICAL INFORMATION

This Consent to Release Medical Information is to be provided to:

*(PLEASE GIVE **COMPLETE INFORMATION** ABOUT THE HEALTH CARE PROFESSIONAL WHO WILL VERIFY YOUR APPLICATION INFORMATION)*

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE #( )_____ FAX #( )_____

I, the undersigned, do hereby consent to the release and disclosure of any relevant medical information to CCT Paratransit Services as called for in Part B of this application for the sole purpose of determining ADA paratransit eligibility. I understand that this information will be shared only with persons making decisions related to my eligibility for paratransit services and to other transit providers needing such information to facilitate travel.

I have read this document carefully and understand that I have the right to revoke this release in writing, excepting information that may have previously been released under this authorization.

_____ _____
Signature of applicant, representative, or guardian Date

_____ _____
Witness Date

If someone other than the applicant has completed this application/authorization, that person must complete the following:

Name_____

Relationship_____

Address_____

Home phone_____

Work phone_____

TDD/TTY_____

I certify to the best of my knowledge that the information provided in this application is complete and correct based upon the information given me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature_____ Date _____

FOR CCT OFFICE USE ONLY:

APPROVED_____ CONDITIONAL_____ UNCONDITIONAL _____
CODE(S) _____

DENIED_____
LIST SPECIFIC REASON FOR DENIAL THAT WILL BE STATED ON THE DENIAL LETTER_____
_____
_____
_____

SIGNED_____DATED_____